| Type 2 Diabetes scope SH subgroup discussions<br>Group 1<br>Date: 6 September 2022 | |
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| **Population** | Are there any specific subgroups that have not been mentioned?<br>Can any of the subgroups be de-prioritised?<br><br>• Subgroups may need separate recommendations<br>• People with lower BMI and T2 diabetes, requires specific consideration in certain ethnic groups (mainly south Asian and far Eastern people). 15% of European ethnicity develop diabetes with BMI less than 25. These should be flagged as specific groups.<br>• Safety considerations are important when deciding specific subgroups.<br>• Missing monogenic diabetes. No therapy is appropriate in this group.<br>• Secondary diabetes. What are appropriate doses following pancreatitis etc.? We are missing where they would sit.<br>• Secondary diabetes not strictly T2 diabetes. Mechanism and treatment of diseases are different so there is a question of overlap with other guidelines for different forms of T2 diabetes.<br>• We will have to consider how overlaps between guidelines are managed.<br>• There are many subgroups, and it may be time-consuming. Do we have the essentials?<br>• Consider serious events of agents used. People with frailty have a smaller therapeutic window. However, broad-brush sub-groups are reasonable.<br>• People with early onset diabetes <40. A lot of people in NWL with T2 diabetes are aged below 40. It had been previously discussed in committee about giving women of childbearing age various drugs.<br>• Need to be more aggressive in getting the target correct in younger people.<br>• Keen to avoid hypoglycaemia resulting from drug treatment. Therefore, tries to avoid sulfonylureas.<br>• Diabetes in women of child-bearing age and gestational diabetes drugs are different. We cannot advise off-license use of medicines in women of child-bearing age. Would be keen to change therapy in women aged 30-40.<br>• Women who are keen to have children should be sufficiently motivated to make lifestyle and dietary changes, which will be much more effective in controlling diabetes than any medication. It is important to emphasize personal responsibility rather than look to different drug treatments to fix all. Is keen to give higher weighting to drugs that preserve pancreatic function |

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| | • This is less early onset diabetes and more common that we think.<br>• Younger patient that are working, SGLTs have adverse events such as polyuria or dysuria. Choice of treatment is important to them.<br>• Newer drugs in younger people is important. People are turning up in ante-natal clinics on drugs they should not be on.<br>• Try to keep as many T2 diabetic women of childbearing age care on secondary care to pick up things like contraception prevention.<br>• Worked on previous draft guidance in 2019. That was good and workable but got shelved in place of new guidance. It looked at sub-groups of T2 diabetes. For this guideline, we are looking at 26-month timeframe. Concern that people will not know where to look for guidance which could result in inertia. Do we really need a new update (other than for maybe GLP1 positioning)?<br>• There is a desire to compare everything with each other and not just with the CVOT drugs.<br>• Health inequalities. We need to think about different socio-economic groups.<br>• Professionals refer to consensus guidelines. There will be a review in September looking at different populations and treatments. Will we also look at this as part of our review?<br>• Health economic modelling is the most important factor. There are other benefits associated with that need to be incorporated into the model. |
| **Key issues and draft questions** | Any comments on these questions?<br>Can any drugs/classes be omitted?<br>We do not propose updating insulin-based treatments compared to one another, do you have any comments on this?<br><br>• We are trying to frame the questions more broadly.<br>• Metformin as combination therapy seems odd. Is it assumed that metformin is first-line treatment? Acarbose has tiny therapeutic window and is not popular with patients due to GI AEs. Effect size is small. Therapeutic effect is minimal.<br>• Could also add meglitinides to exclusion list, which is used in small scale.<br>• Drug treatment has moved on since 2015. Need justification for what SoC is. What intensification will be. More needs to be done to understand what this means.<br>• Should be individualised targets and what is realistic with work etc.<br>• Guideline should help clinicians work out which types of people may treatments be useful in.<br>• NWL have incorporated this. GLP1's place is up for re-look in place of new cardiovascular data. |

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| | • Not including insulin?<br>• Clinicians using analogues. Are there benefits of SEs for this.<br>• There are many people in whom it will benefit.<br>• Getting basal insulin guidance right is important. Insulin is a medicine.<br>• If we do anything, looking at basal insulin in combination with GLP may be useful, but this may open floodgates to different combination therapies.<br>• Studies have shown no benefit with fast-acting, and increased hypos.<br>• Keep an eye on biosimilars. Need to think about carbon footprint (which is huge in diabetes). Switching therapy needs consideration. Will guideline consider switching therapy between medicines within a drug class?<br>• Those details will be discussed as part of the protocol with committee.<br>• Does it not make sense to split questions, and have one recommendation out then another?<br>• Problem is evidence goes out of date quickly. Agrees with PD's suggestion. |
| **Critical issues** | Are there any critical issues relating to medicines for T2D that aren't included in the scope?<br>Any safety issues?<br>Areas with the greatest potential for improved patient outcomes?<br>Areas with potential for NHS resource savings? |
| **Outcomes** | Any comments on the outcomes?<br><br>• We will include weight gain<br>• Need to be cautious of including too many endpoints<br>• Need to be careful with renal wording. With SGLT2 initiation, we do see something akin to acute kidney injury, which then stabilises.<br>• Health-related quality of life: what will we be assessing<br>• We don't discuss this at this stage but will be using validated techniques.<br>• Prioritise the list in terms of importance.<br>• Would serious adverse events include severe hypoglycaemia?<br>• We are intending to capture that |

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| **Health economics model** | Any comments on HE modelling for this guideline?<br><br>• Weight loss is not properly measured. Should be adjusted for. Hazard ratios for cardiovascular outcomes: having them non-adjusted for population differences is not correct. Intensification: there needs to be more justification around how this was defined. More clinical experts should be consulted. Model should be open to everyone.<br>• There needs to be more done regarding intensification. Dose-relationship response is an important consideration. The most efficacious dose is higher doses for GLPs.<br>• There will need to be a lot of sensitivity analyses conducted to understand the clinical drivers, intensification, QoL, treatments, hazard ratio adjustments. Differences will need to be fleshed out.<br>• Thoughts about combination therapy (two drugs in the same tablet). Carbon-mapping: metformin and SGLT2: switching to a combination of the two in a single tablet will have the same positive impact as changing from pressurised metered dose inhalers (pMDIs) to dry powder inhalers (DPIs) in asthma.<br>• Complications: CVOTs: if someone had prior CV.<br>• Can the cost modelling incorporate clinical benefits of all 3 agents (triple therapy including GLPs)?<br>• costs of complications, long-term costs need modelling.<br>• PD: CV complications? Are we looking at QRISK? Hippesley-Cox reported to 80% of diabetic patients will have score of 10 or more. |
| **GC membership** | Any comments on the committee membership composition?<br><br>• Dietician |